New Hampshire DHHS

Request for Proposals # 12-DHHS-CM-01
For Medicaid Care Management Services
Cost Proposal Instructions and Data Book

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Agenda

- Rate Cell Definitions
- Bidding Instructions
- Data Book Information
- Risk Adjustment Process
- Q & A

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Rate Cell Definitions

Rate Cell Definitions

- The following Medicaid recipients will be mandated for enrollment into MCOs, with member opt-outs as noted:
  - Old Age Assistance (OAA)
  - Aid to the Needy Blind (ANB)
  - Aid to the Permanently and Totally Disabled (APTD)
  - Medicaid for Employed Adults with Disabilities (MEAD)
  - TANF / Poverty
  - Foster Care / Adoption (with member opt out)
  - Home Care for Children with Severe Disabilities (HC-CSD), commonly known as Katie Beckett (with member opt out)
  - New Hampshire Healthy Kids Silver Children's Health Insurance Program (CHIP) population, which will transition to Medicaid expansion coverage
  - Populations with third party liability coverage, except for members with Veteran's Administration (VA) benefits
  - Auto eligible and assigned newborns
  - Medicare-Medicaid Dual Eligibles (with member opt out)

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Rate Cell Definitions

- The following Medicaid eligible populations will be moved to the Care Management Program in Steps 2 and 3 of the program:
  - Medicare-Medicaid Dual Eligibles (mandatory enrollment with CMS waiver)
  - Foster Care / Adoption (mandatory enrollment with CMS waiver)
  - Affordable Care Act (ACA) expansion group
- The following Medicaid eligible populations will remain in the fee-for-service program:
  - Members with VA benefits
  - Members with Family Planning only benefits
  - Initial part of month and retroactive / PE eligibility segments
  - Spend-down
  - QMB / SLMB only
- There are a total of 22 rate cells across 11 different eligibility categories

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Rate Cell Definitions

Table 1 New Hampshire Department of Health and Human Services Medicaid Care Management Program Rate Cell Definitions				
Rate Cell	**Age / Gender Categories**	**Aid Code Categories**	**Dual Status Code**	**Other Criteria**
Low Income Children and Families	2 - 11 months 1 - 5 6 - 13 14 - 18 female 14 - 18 male 19 - 44 female 19 - 44 male 45+	20, 21, 22, 24, 27, 28, 2E, 2F, 2H, 2U, 2V, 2W, 2X, 61	00	Includes Healthy Kids Silver CHIP population
Foster Care / Adoption	All	40, 41, 42	00	
Breast and Cervical Cancer Program (BCCP)	All	86	00	
Disabled Children (non-dual / non-NF resident)	All	2B, 2C, 2D, 2K, and 30-32	00	Age <19 for category code 30-32
Disabled Adults (non-dual / non-NF resident)	19 - 44 female 19 - 44 male 45+	30, 31, 32, 50, 51, 52, 70, 71, 72, 80, 81, 82, 83, 84, 85	00	Age 19+ for category code 30-32

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Rate Cell Definitions

Table 1 New Hampshire Department of Health and Human Services Medicaid Care Management Program Rate Cell Definitions				
Rate Cell	**Age / Gender Categories**	**Aid Code Categories**	**Dual Status Code**	**Other Criteria**
OAA (non-dual / non-NF resident)	All	10, 11, 12	00	
Nursing Facility (NF) residents (non-dual)	All	All aid categories	00	Presence of a claim under Fund Code B, C, or E (determined each month)
Nursing Facility (NF) residents (dual)	All	All aid categories	02, 04, 08	Presence of a claim under Fund Code B, C, or E (determined each month)
Dual eligibles (non-NF resident)	0 - 44 45 - 64 65+	All aid categories	02, 04, 08	Medicare coverage (excluding SLMB and QMB)
Newborn Kick Payment		All aid categories	00	First two months of life (e.g., for a baby born on July 15, all costs incurred in July and August)
Maternity Kick Payment		All aid categories	00	Service description below

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Rate Cell Definitions

- The Maternity Kick Payment includes hospital inpatient delivery services, hospital outpatient, and emergency room delivery services, as well as professional delivery services.
  - Hospital Inpatient providers, with DRG codes of 765 – 768, 774 – 775
  - Hospital Outpatient providers with a primary diagnosis code of v27.0 – v27.9, 650, and 651.01 - 669.92 (with the 5th digit being 1 or 2)
  - For all other providers only delivery and post-partum care services are included (CPT codes 59400, 59409, 59410, 59430, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, 00850, 00857, 00946, 00955, 01960, 01961, 01967, and 01968)
- Prenatal services are not included in the Maternity Kick Payment
- Fees associated with global reimbursement CPT-4 codes were allocated using RBRVS ratios to exclude the cost of prenatal care from the Maternity Kicker Payment

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Bidding Instructions

Bidding Instructions

- In order to be considered complete and eligible for the evaluation, bids must fully comply with the following:
  - Bidder must submit its cost proposal using the Cost Proposal Template included in Appendix I
  - Bidder must provide a cost proposal for each of the 22 different rate cells
  - Bidder cannot make alterations of any kind to the rate cell structure
  - Bidder must include an actuarial certification, completed and signed by a Member of the American Academy of Actuaries, that the bidder's cost proposal is actuarially sound
  - Bidder must submit an actuarial memorandum that contains a description of the data, methodology, and assumptions used to develop the bidder's cost proposal
  - Throughout the Cost Proposal Template, bidder is only to fill out the cells shaded in yellow

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Bidding Instructions

- Additional bidding instructions:
  - Cost proposals are to be quoted on a PMPM basis by type of service for a full month of enrollment
  - The maternity and newborn kick payments are to be quoted as a case rate for services as defined in the rate cell definitions
  - Pricing proposals are effective for year one of the program (July 1, 2012 - June 30, 2013)
  - Cost proposals must provide details by broad type of service according to the Data Book and the Service Category Definition tab of the Cost Proposal Template
  - Cost proposals are to be quoted assuming a risk score of 1.00 for each rate cell, where a 1.00 risk score represents the average acuity of the population included in the data book

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Bidding Instructions

- Additional bidding instructions:
  - Cost proposals for prescription drugs should be net of any supplemental rebates and net of the FFS adult copays that will remain in place under managed care
  - Cost proposals are to be quoted assuming FQHC and RHC providers are paid their normal prospective encounter rates
  - Cost proposals are to be net of TPL recoveries and reinsurance recoveries and should not reflect premium tax

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Data Book Information

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Data Book Information

- Eligibility data:
  - Member month counts were calculated from eligibility data files extracted from New Hampshire's MMIS system
  - Each day of Medicaid eligibility is counted and months of eligibility are determined by dividing the total number of eligible days by 30.42
  - Rate cell assignment is based on aid category, age, and dual status code (See Table 1)
  - The spend down population and the individuals with VA benefits are excluded on a month by month basis
- Retroactive eligibility:
  - Two months of claims and eligibility are removed for all Medicaid beneficiaries except newborns

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Data Book Information

- Cost and utilization data:
  - Claims with dates of services between January 2008 and December 2010 with dates of payment through August 2011
  - Claims for FQHC and RHC providers reflect their normal prospective per encounter rates
  - Prescription drug claims do not reflect FFS rebates
  - Prescription drug claims are net of FFS copays, which will remain in place under managed care
  - Adjustment to remove enhanced maternity reimbursement to Coos County Hospital
    - Will be made outside of the MCO capitation payments by DHHS
  - We removed the Indirect Medical Education payments that are in the MMIS data using the historical multipliers by Provider Code

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Data Book Information

- Incurred but not reported (IBNR) claims
  - We used Milliman's *Claim Reserve Estimation Workbook (CREW)* to calculate the completion factors by population and type of service shown in Appendix E of the data book
  - Due to the amount of runout, the completion factors are entirely based on a traditional lag method
  - The lag method reflects the historical average lag between the time a claim is incurred and the time it is paid
- Low Income Children vs. Health Kids Silver (CHIP) risk scores
  - The Healthy Kids Silver (CHIP) population will be covered under the Medicaid managed care program, but the experience data for the population was not available for inclusion in the data book
  - CRG risk score information calculated by DHHS can be used to adjust bids

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Data Book Information

Table 2 New Hampshire Department of Health and Human Services Low Income Children vs. Healthy Kids Silver (CHIP) Risk Scores						
Age Group	CY 2008		CY 2009		CY 2010	
	Scored Members	Average Risk Score	Scored Members	Average Risk Score	Scored Members	Average Risk Score
Medicaid Low Income						
Age 1 to 5	16,440	0.570	17,974	0.581	20,038	0.552
Age 6 to 13	22,776	0.657	24,495	0.603	27,286	0.570
Age 14 to 18 Female	6,030	0.741	6,337	0.671	7,054	0.643
Age 14 to 18 Male	6,028	0.801	6,510	0.731	7,280	0.674
Total	51,274	0.656	55,316	0.619	61,658	0.585
Healthy Kids Silver (CHIP)						
Age 1 to 5	886	0.448	838	0.439	932	0.457
Age 6 to 13	1,987	0.494	2,049	0.503	2,280	0.485
Age 14 to 18 Female	628	0.553	668	0.565	781	0.598
Age 14 to 18 Male	700	0.502	694	0.510	774	0.512
Total	4,201	0.494	4,249	0.501	4,767	0.502

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Data Book Information

- Non-emergency transportation and hospice claims:
  - Non-emergency transportation services are currently DHHS administrative expenses, but will be included in capitated services
  - Historical non-emergency transportation expenses are presented in Appendix F
  - A hospice benefit was introduced in July 2010 and is part of the covered services under the care management program
  - Historical hospice expenses (not included in MMIS claims) are presented in Appendix G
- Third party liability (TPL) recoveries:
  - MCOs are expected to pursue and collect TPL recoveries from other payers
  - Table 3 shows a summary of the TPL recovery amounts that should be used to adjust the paid claims data shown in Appendix A

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Data Book Information

- Additional covered services not in data book:
  - MCOs must provide for payment to American Academy of Pediatrics trained and annually certified primary care providers and pediatricians who:
    - Conduct an oral exam,
    - Provide age appropriate anticipatory guidance and risk assessment, and
    - Apply fluoride varnish to the teeth, when clinically appropriate.
  - Services are for members aged 6-36 months during well child care no more than twice per year
  - Bidders should include the cost of these services in their cost proposal

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Data Book Information

Table 3 New Hampshire Department of Health and Human Services Third Party Liability by Calendar Year and Category of Service			
Category of Service	**CY 2008**	**CY 2009**	**CY 2010**
Inpatient	$159,671	$493,467	$514,549
Inpatient Crossover	0	48,913	5,340
Outpatient	196,524	389,251	369,007
Outpatient Crossover	71	63,505	1,920
Medical	565,068	571,962	575,939
Professional Crossover	4,369	21,604	3,914
Prescription Drugs	235,521	229,231	389,621
Invalid Claim Type	0	105	0
Not Matched To TCN	13,008	683,598	768
Total	$1,174,232	$2,501,636	$1,861,059
Percent of Paid Claims	0.31%	0.60%	0.45%

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Risk Adjustment Process

Risk Adjustment Process

- The capitation rates for the following non-dual rate cells will be further adjusted to reflect the acuity level of the population enrolled in each MCO using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx):
  - Low Income Children and Families
  - Foster Care / Adoption
  - Disabled Children
  - Disabled Adults (non-Dual / non-NF resident)
  - OAA (non-Dual / non-NF resident)
  - Nursing Facility Residents (Medicaid only)
- An MCO Risk Factor will equal the average risk factor across all beneficiaries that a MCO enrolls compared to the entire population eligible for the managed care program

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Risk Adjustment Process

- Risk adjustment for July 2012 through December 2012 capitation payments will be based on calendar year 2011 FFS data
- Risk adjustment for January 2013 through June 2013 capitation payments will be based on SFY 2012 FFS data
- Will only include beneficiaries with at least six months of eligibility
- First quarter scores will be set to 1.000 with retrospective settlement at the end of the quarter
- Most current available month's enrollment will be used to set case mix for the following quarter
- Retrospective settlements will be made at the end of each quarter throughout the first year of the program

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Risk Adjustment Process

- With enrollment stabilizing in the second year, retrospective settlements should not be required
- Case mix will be set twice per year

Table 4 MCO Capitation Rate Risk Adjustment Schedule Years 1 and 2 of New Hampshire Care Management Program		
Program Quarter	**MCO Risk Factor Based on Enrollment in**	**Retrospective Settlement Based on Enrollment in**
1	Set = 1.00 at program start	7/12 – 9/12
2	8/12	10/12– 12/12
3	11/12	1/13 – 3/13
4	2/13	4/13 – 6/13
5 and 6	5/13	None
7 and 8	11/13	None

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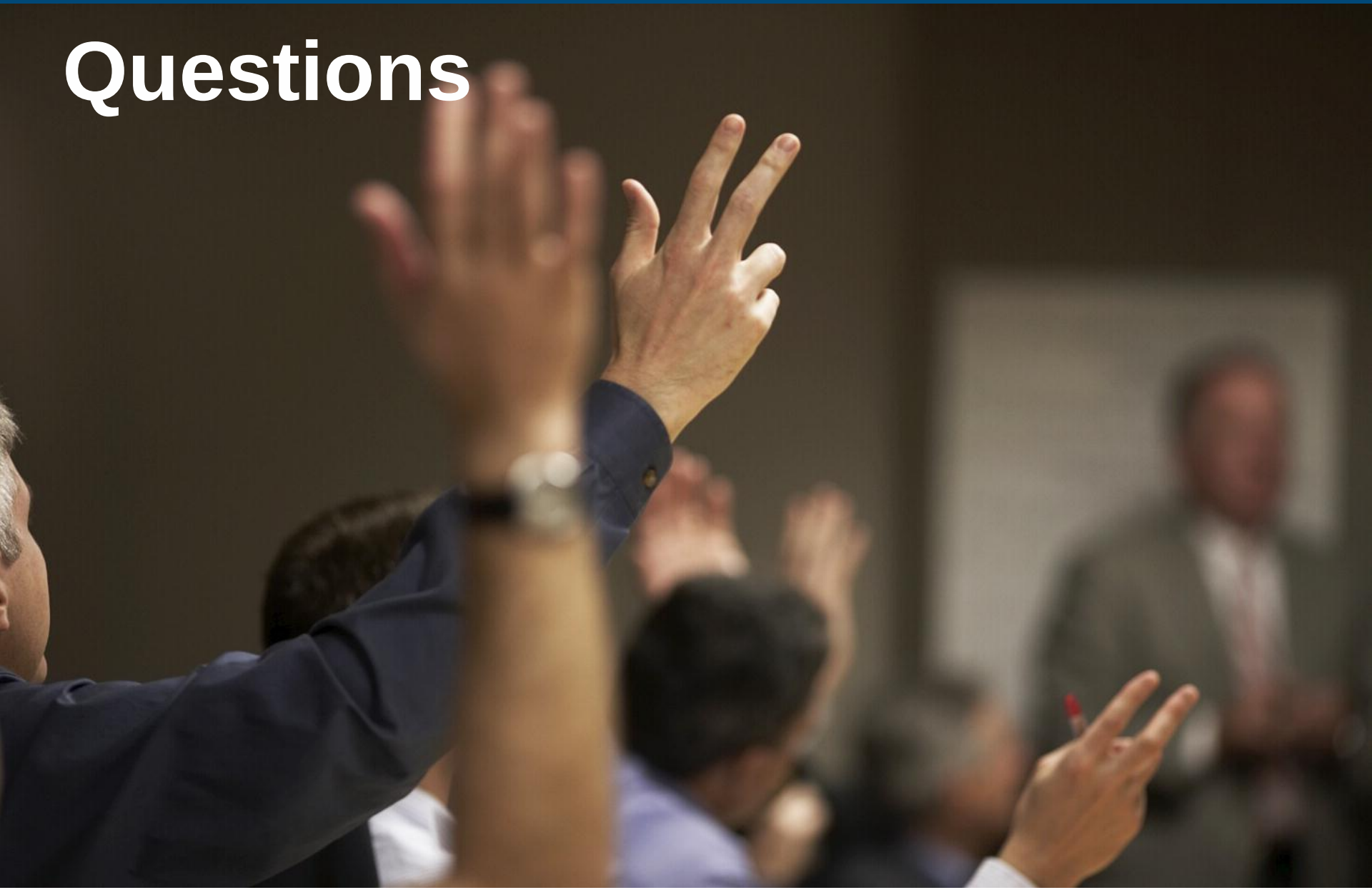
Questions



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